AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Client Name:_____ **Date of Birth:**_____

Authorization is hereby voluntarily granted to River Birch Counseling Center by the below signed client or client guardian to exchange information with the following person or organization:

_____
Name of Person and/or Organization

_____ _____ _____ _____ _____ _____
Street **City** **State** **Zip** **Telephone** **Fax**

METHOD FOR RELEASING: (check all that apply): ◯ **Oral** ◯ **Written** ◯ **Fax**

INFORMATION TYPE: The following checked items are being: ◯ Released ◯ Requested

◯ Assessment
◯ Diagnosis
◯ Present Participation in Treatment
◯ Treatment Plan or Summary
◯ Progress in Treatment
◯ Current Treatment Update
◯ Demographic Information
◯ Psychosocial Evaluations
◯ Psychological Evaluations
◯ Psychiatric Evaluations
◯ Medical Information
◯ Continuing Care Plan
◯ Medication Management Information
◯ Educational Information
◯ Legal/Criminal Justice Information
◯ CD/DMH Information
◯ Discharge/Transfer Summary
◯ Toxicology/Drug Screen Results
◯ Other: _____

PURPOSE OF INFORMATION: Treatment/Service Coordination and
◯ Other _____

Release/Obtain alcohol/drug abuse and HIV/AIDS information is protected by Federal Confidentiality (42CFR)
◯ Please check here if this section does not apply.

If not checked, please answer the following questions:

◯ YES I understand that I am not required to consent to the release of alcohol, drug and/or HIV information.

◯ YES ◯ NO I give my consent to release/obtain drug and alcohol information:
Client and Parent/Guardian initials required _____

◯ YES ◯ NO I give my consent to release/obtain HIV/AIDS information:
Client and Parent/Guardian initials required _____

I understand that this authorization is subject to revocation at any time, except to the extent that River Birch Counseling Center has already taken action on this authorization. If not revoked earliet by written notice to River Birch Counseling Center, this authorization will expire as follows:

Check One:

◯ One year from date of signature below.
◯ Upon reaching (Specific date, event or condition) _____

Once the requested information is disclosed pursuant to this authorization, River Birch Couneling Center will no longer have control over the information, and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy under the Health Insurance Portability and Accountability Act (HIPPA).

_____ _____ _____ _____

Client Signature Date Parent/Guardian Signature (if applicable) Date